Health Care Access and Reimbursement Task Force

1-3:30 PM University of Baltimore Technology Center

June 10, 2008

Task Force Members Present: Secretary John Colmers (Chair), Senator Rob Garagiola, JB Howard, Ralph Tyler, Dr. Joseph Fastow, Dr. George Bone, David Wolf, Stuart Guterman, Dr. Ivan Walks, Delegate Robert Costa, Fannie Gaston-Johansson. Absent: T. Eloise Foster, Senator Thomas Middleton, Delegate Joseline Pena-Melnyk

Staff present: Rex Cowdry, Ben Steffen, Lydia Isaac, Linda Bartnyska, Alice Burton, Anne Hubbard

1. Secretary John Colmers, Chair, called to order meeting at 1:15 PM. The Task Force approved the May 12, 2008 meeting minutes as written.

2. Patient-centered medical home- Michael Barr, MD, MBA, FACP, American College of Physicians (ACP)

Patient-centered care is one of the IOM's six domains of quality and may be an important factor in health care reform. Attributes of patient-centered primary care include superb access to care, patient engagement in care, care coordination, integrated comprehensive care, and ongoing, routine patient feedback to a practice, among others. Quality primary care leads to better health outcomes, lower costs, and greater equity in health. A patient-centered medical home (PCMH) can be an important part of this, and is based in part on the Chronic Care model. The principles of a PCMH include personal physicians, whole person orientation, quality and safety, and enhanced access to care, among others. Defining a medical home is challenging, and the ACP is working on refining their definition. What a PCMH would cost is unclear, partly because varying data makes different assumptions, though both US and international data exist to show a relationship between primary care and improved quality and decreased costs. A medical home can also reduce or even eliminate racial and ethnic disparities in access and quality for insured persons. Customer satisfaction among patients with a medical home is higher than those without one. A PCMH also creates a new way of doing primary care that may be attractive to medical students, many of whom are no longer choosing to enter into primary care. A PCMH does not limit referrals, but emphasizes the right referral at the right time to the right provider, and is built on a business model to show that cost is improved and customers are satisfied. Alternatively, other models simulate more volume (not quality).

If the PCMH model works, primary care will stabilize and possibly grow; care coordination and referrals will be based on service responsiveness, partnership/collaboration, and performance; and patients will receive better care. Many demonstration projects already exist among commercial plans, Medicaid, and Medicare, and interest is expanding. Health information technology is occurring alongside of the PCMH, offering many features but also presenting cost and legal barriers to some physicians. The ACP PCMH model does not require electronic health records but does require a system of organized charts on which physician practices' are scored.

3. What should states do to promote primary care? Barbara Starfield, MD, MPH, The Johns Hopkins University School of Public Health

Any reform that does not address primary care will fail; a medical home may or may not be part of the answer but it is a necessary component of primary care reform. When comparing life expectancy with per capita GDP across the world, the wealthier the county the higher the life expectancy, though there is tremendous variability. All the countries which are not oriented towards primary care are experiencing declines. Primary care leads to better health outcomes, lower costs, and greater equity in health; primary care requires health system policies conducive to primary care practice and health services delivery that achieve the important functions of primary care. The key factors necessary for achieving an effective health system in both the developed and industrialized countries are: universal financial coverage (does not have to be single payer but has to be under governmental control or regulation); efforts to distribute resources equitably (according to need); no or low co-payments; comprehensiveness of services; skilled delivery attendants; and immunization coverage. Countries that have these policies are more likely to have better health care outcomes; the better ranked the policies, the better the rank of practices. Further, most countries have more comprehensive primary care than the US. The most important feature of a primary care system is the breath of services provided—that what can be done by the PCP is done by the PCP; a good primary care system will make use of specialists more effectively.

The evidence-based functions of primary care are for it to be the first contact, to be person-focused (rather than disease focused) care over time, comprehensiveness, and coordination. High primary care countries have lower loss of life due to infant mortality, and the difference between the two (high primary care countries and low primary care countries) is getting greater over time. These countries also have lower heart disease mortality rates, total mortality rates, and earlier detection of various cancers. The opposite is true of higher specialist supply areas, which is associated with worse outcomes. A major role of primary care is to assure that specialty care is more appropriate and, therefore, more effective. The US has a very high rate of specialty referral rates, often leading to adverse outcomes. Seeing many different physicians also has an adverse affect on health outcomes.

Regarding the patient-centered medical home (PCMH), the term is vague and defined variably, and it is not known if electronic health records will solve the problems they attest to. Primary care needs be composed of evidence-based primary care functions; payment should be based on their achievement over a period of time. Any payment system that rewards specific services will distort the main purpose of medical care: to deal with health problems effectively, efficiently, and equitably. To achieve these goals states can: advocate for policies conducive to primary care practice at the federal level; support financial incentives for primary care training by medical academia; support financial incentives for loan repayment and practice in primary care; provide bonuses for 'medical home' practice that achieve the functions of primary care, especially comprehensiveness of care; and insist that evaluations address primary care functions.

Task force members noted that other countries that were mentioned that do better than the US are low malpractice environments. Ms. Starfield noted that malpractice costs are a small part of the excess in the US, and that half of malpractice suits are for overuse rather than underuse, so it is not evidence-based to assert that primary care doctors are not doing things based on fear of

litigation. It was further noted that it is not the size of the practice that determines the success of primary care.

4. Carrier initiatives to promote primary care—Jon Shematek, MD, CareFirst, and Vera Dvorak, MD and Eric Sullivan, MS, MBA, United Health Care

CareFirst developed their PCMH model in response to indicators of poor quality and inefficiency identified in an IOM report, along with increasing employer demands for better quality and lower cost. CareFirst does not create quality standards or conduct evaluations so they use externally developed NCQA standards which are excellent starting points. NCQA standards include patient access and communication, patient tracking and registry, care management, and electronic prescribing, among others. CareFirst is in the design stage of the medical home process; the pilot program, CareFirst Quality Rewards program, is in collaboration with Bridges to Excellence and NCQA and is planned to launch in 2009. The program is voluntary, with a payment system designed to incorporate traditional FFS and prospective care coordination fees. Rewards are based on quality and efficiency. CareFirst recommends the development of PCMH pilots and demonstration projects along with rigorous evaluation. Task Force members noted that patient self-management is very challenging. CareFirst is in the process of determining what physicians need in an effort to create incentives for physician buy-in.

United Health Care is also engaged in creating a PCMH as an approach to providing comprehensive primary care of adults, youth, and children. United's model approach emphasizes enhanced access, care and chronic condition management, team care, performance measurement, assessment and improvement, and clinical information systems. United is also pursuing Proof of Concept pilots in other markets, including in Maryland. These pilots can serve as a learning lab to inform United on the best way to assist practices in becoming medical homes. Patients will also need to take an active role in their medical decisions and take ownership of their own health and make good health decisions. The purchaser will need to demonstrate leadership and insist on well-structured research and measurement of the value of the medical home model. The pilot's success will be measured by the physician's and the patient's experience, quality, and resource use. Electronic health records (EHR) are not required and can be expensive.

Task Force members inquired how long the average enrollee stayed with United, which varies depending on the product and market. Members also inquired if small practices can survive in this environment since they have no negotiating power, cannot afford EHR, and do not have the staff to move into this new era. Part of the Task Force's discussion for the next meeting will focus on this. ACP acknowledges the need to be innovative and creative on how to deal with this situation and has been and will continue to be working on it. Infrastructure has to coexist with financial incentives to make this possible.

5. Review of Initiatives and Recommendations to Promote Primary Care for the Medicare Population, Ben Steffin, MHCC.

Current initiatives include the 2006 revaluation of emergency and management services, the promotion of medical home model, fee schedule adjustment focusing on primary care specialties, and a pay-for-performance initiative along with various care management demonstrations implemented by CMS. The CMS demonstration project will begin in September 2008, and Maryland will be in a unique position to compete for it. MedPAC has also made a series of

recommendations to be included in a June 2008 report to Congress regarding primary care and medical homes. One challenge will be to reschool patients who have become trained to view their primary care doctor as an in between, a means to an end which is the specialist, and a limited provider.

6. Task Force discussion and options for recommendations

Options suggested for recommendations include: Endorse multi-stakeholder promotion of primary care practices; actively compete for the CMS medical home demonstration; endorse employer initiatives to require payers to elevate importance of primary care; and/or endorse increasing payment to primary care providers through elevated E&M fees.

Task Force members noted that the problem needing to be addressed is the impending shortage of physicians in Maryland, especially in primary care; it is in part related to differences in reimbursement rates for PCPs vs specialists, which are fairly great. Given the debt of graduating medical students this is an issue; there is widespread contention that physician reimbursement levels overall are lower in MD than nationally.

Additional items to consider include loan repayment and loan forgiveness programs. Regarding reimbursement levels, one of the MedPAC recommendations was a move away from CMS/Medicaid policies. Further, forces also exist within medical schools to move them towards primary care and specialty care; in Canada they controlled the number of training spots for primary care and specialty care. Medicare tried to do this but it did not have much affect in part because hospitals stood to gain so much more money from high end specialties. Efficiency gain in the system is better than throwing money at a broken system.

Adjournment

4 PM

Next meeting July 11, 2008.

Respectfully submitted,
Laurel Havas